Health Home Managed Care Work Group Meeting

November 4, 2015

Agenda

- Welcome – Webinar Format, Questions

- Schedule Updates for MAPP, Health Home Billing and Enrollment of Children in Health Homes

- Status of Administrative Service Agreement Templates

- Update from Health Home/ MCO Coalition – Standardized MAPP Work Flow, HCBS Plan of Care

- Health Home Development Funds

- Behavioral Health Strategic Task Force Updates

- End the AIDS Epidemic

Schedule Updates for MAPP, Health Home Billing and Enrollment of Children in Health Homes

Schedule Updates Released on October 30, 2015

Schedule changes will help ensure that providers have an appropriate amount of time to adjust provider systems and procedures for the implementation of MAPP and other related Health Home billing requirements and to address system functionality needed to adequately support Phase 1 MAPP requirements

MAPP Release/Billing Changes	Date
Phase 1 of MAPP	March 2016
Pre-population of HH High Medium Low Rates (Clinical Functional Indicators Available in MAPP)	Begins April 2016
Health Home Billing Attestations (Adults and Children)	May 1, 2016
Adult Behavioral Health Transition ROS	July 2016
Extend Legacy Rates and Direct Billing	through August 31, 2016
High Medium Low HH Rates take effect Enrollment of Children in Health Homes Begins	September 2016 Service Dates

Phase 1 MAPP Functionality

Phase 1 of the MAPP Health Home Tracking System (HHTS) will provide users with the following functionality that is not in the current Health Home Tracking System:

- ✓ Care Management Agencies will have access to the MAPP HHTS.

- ✓ Actions within MAPP can be performed individually or in bulk through online screen entry or through file transfer.

- ✓ The creation, acceptance and rejection of assignments made from the Managed Care Plan to the Health Home to the Care Management Agency will be tracked in MAPP HHTS.

- ✓ New concept of "accepting" of assignments, transfers, and referrals by all users and of Health Home "accepting" assignment, outreach, and enrollment submitted by Care Management Agencies

- ✓ Allow seamless "warm" transfer of enrolled Health Home members between health homes

- ✓ Uses status types and new end date reason codes for members in Assignment, Outreach, and Enrollment to better track members in outreach hiatus, incarcerated and lapsed Medicaid eligibility

Readiness Activities of 16 Contingently Designated Health Homes Serving Children

- The Status of Readiness Activities and the Impact of Phase 1 on the timeline for launching Phase 2 of MAPP has prompted schedule change for in enrollment date from January 2016 to September 2016

- Readiness status of 16 Contingently Designated Health Homes

  - Potential changes in proposed governance structure will likely require the re-submission of Applications to serve children

  - 2 are new Health Homes and will have readiness challenges

  - 14/16 have few (if any) BAAs signed, many need new ASAs, and 5 have no MMIS ID which is crucial for billing

  - 8/16 HH have not executed new Business Associate Agreements with children's providers *and* have not submitted their billing readiness attestation or indicated they have billing software

  - Many indicated delay would be welcome and helpful in ensuring readiness

  - Link to status of readiness activities
    https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hhsc_9_30_2015_readiness_review.pdf

- Webinar will be scheduled in December to provide updates on Health Homes Serving Children (status of readiness activities, CMS/Complex Trauma Definition)

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Phase 2 of MAPP Functionality for Children's Health Homes

- MAPP is critical component of the design and implementation of the Children's Health Home model

- CANS-NY Assessment tool will be integrated into MAPP

- Billing, rate information and CANS-NY algorithms (High, Medium, Low)

- Referral Portal for Children (under 21)

  - Community Referral (by LGU/SPOA and LDSS, and eventually others) for Assignment

  - Assignment and Enrollment by Health Homes, Plans and Care Managers

- Consent Management

  - Consent to Refer

  - Consent to Enroll

  - Consent to Share Information (Protected Services)

Documenting MAPP
Clinical and Functional Indicators

- Health Homes and CMAs have asked for guidance on the documentation they should obtain/maintain in order to support responses to the clinical and functional indicators in MAPP.

- The State provided some suggestions for documentation and feedback distributed at the last HH MCO WG Meeting

- Guidance should be finalized by March 2016 (in advance of April 2016 pre-population date for HML in MAPP)

- The clinical and functional indicators were developed by a sub-group of the Health Home MCO Workgroup – suggest a sub-group reconvene (HH/MCO Coalition?) to review suggestions and make recommendations for review by HH MCO WG

Administrative Service Agreements

Health Home Administrative Services Agreements between MCOs and Health Homes

- MCOs have entered into Administrative Services Agreements (ASAs) with one or more Health Homes to provide Health Home care management services to enrollees. Options for ASAs have included:

  - Using the DOH standard template, as is with no changes;

  - Using the DOH standard template with modifications;

  - Using DOH Key Provisions to develop a customized contract.

- The updated ASA and key provisions were distributed via listserv and are located on the Health Homes website:
  https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care.htm

- The Final Form DOH 5060 for Submitting revised ASAs to the Department is underdevelopment and will be released shortly

- MCOs and Health Homes will need to amend their ASAs to reflect these changes.

Health Home Administrative Services Agreements between Health Homes and MLTC Plans

- In addition to the ASAs used by MCOs and Health Homes for mainstream plan members, DOH has developed two additional ASA templates for use by MLTCs:

  - For members that are part of the Adult Home stipulated settlement and that are enrolled in MLTCs and Health Home: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care.htm

  - For members that are enrolled in MLTCs and Health Home and not part of the Adult Home Settlement, DOH/MLTC is finalizing the draft ASA

- For MLTC members, Health Homes bill the State the HH rate directly for members enrolled in Health Homes, MLTC continue to bill capitated rate for the member

- Members enrolled in HH/MLTC should NOT be dis-enrolled from HH; they are eligible for the optional HH benefit.

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Update from
Health Home/MCO Coalition

Standardizing Workflow:
Assignment, Outreach, Enrollment

- Overview by HH/ MCO Coalition of Work Flow Document

- Feedback MAPP concern: Recommendations that increases the time between uploading to downloading from the MAPP HH Tracking System will impact the real time integrity of the information in the system and installs gaps in time in information that may be needed to submit a claim to pay downstream care managers

Behavioral Health HCBS Plan of Care

- The Adult BH HCBS Plan of Care (POC) template is now available on the HH website [Health Homes for Individuals in HARPs & HARP eligibles in HIV SNPs](#). The template has been sent to the HH Listserv and to the HH/MCO workgroup. Thanks to the HH/MCO workgroup for all their input and assistance.

- The template has incorporated all the Federal Rules and Regulations pertaining to the adult BH HCBS Plan of Care.

- If an entity chooses not to use the template they must ensure that all the Federal Rules and Regulations pertaining to the Adult BH HCBS POC are incorporated into their Adult BH HCBS POC and it includes all the elements included in the template

- A checklist of the Federal Rules and Regulations for the Adult BH HCBS Plan of Care was also posted on the HH Website at the above link and sent to the HH Listserv and the HH/MCO workgroup.

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Community Mental Health Assessment Updates on Training and Billing Information
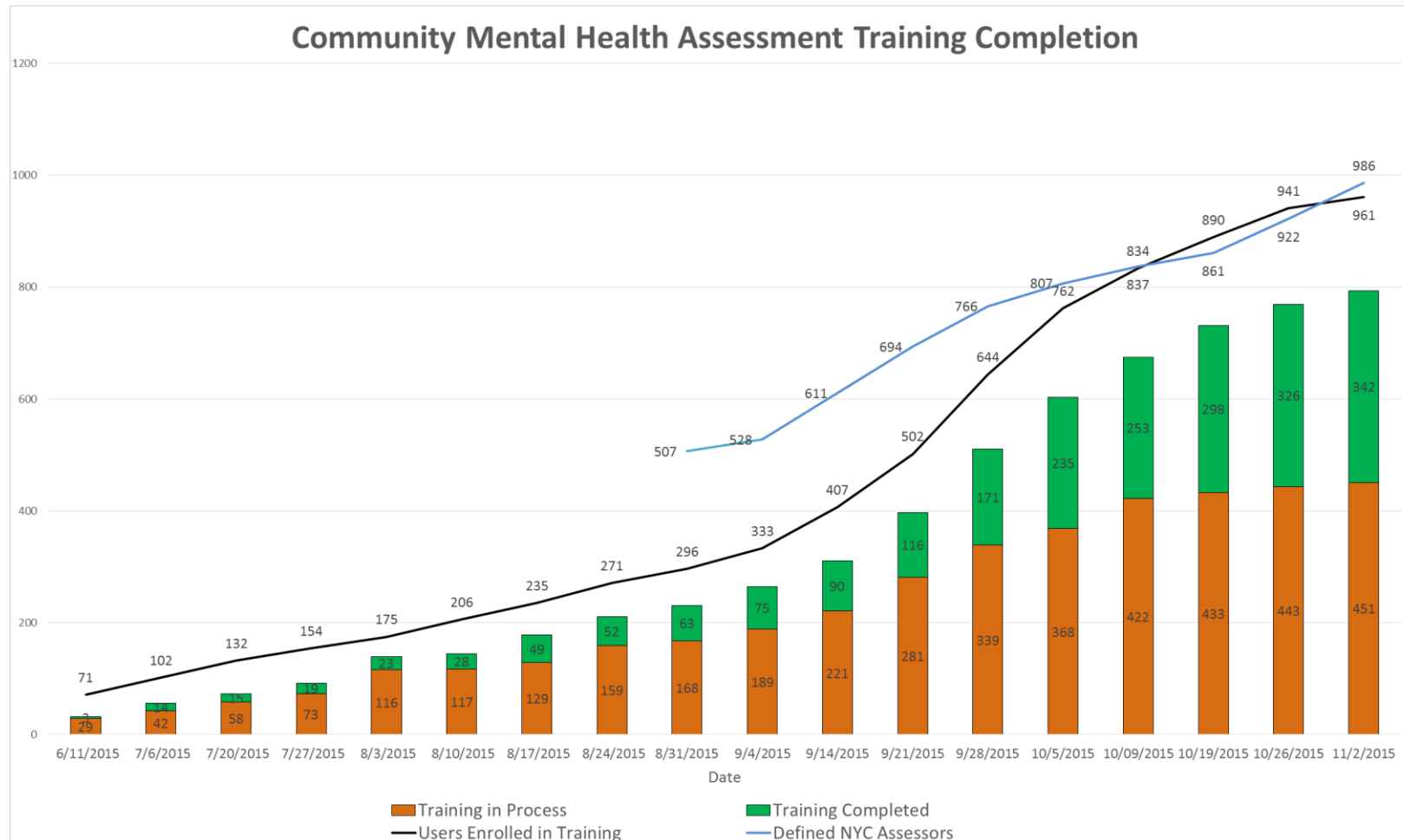
Community Mental Health Assessments

- Health Home Care Managers who will be conducting BH HCBS assessments need to complete required training for the NYS Community Mental Health Assessment
  - o Training was made available on May 15, 2015
  - o Assessors will need HCS access to complete assessments and training
  - o More information on how to access training can be found at
    http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/harp_hiv_snp.htm

- Reminder: Health Homes, Care Management Agencies, MCOs, and ACT teams in the role of Health Home Care Managers need to designate a Single Point of Contact for care management activities related to the behavioral health implementation and the NYS Community Mental Health Assessment
  - o Letter dated July 27, 2015 has information on where to submit Single Point of Contact
  - o This letter can be found at:
    http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/bhmc_nyc_imp.pdf

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Status of Completed Trainings for Community Mental Health Assessments

Community Mental Health Assessment Trainings Completed	
Enrolled Users	961
In process (Completed at least one activity)	451
Completed Course	342

- Feedback from Health Home community on training activities

Status of Completed Trainings for Community Mental Health Assessments

Community Mental Health Assessment Training Completion

Legend:
- Training in Process (orange)
- Training Completed (green)
- Users Enrolled in Training (black line)
- Defined NYC Assessors (blue line)

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Process for Billing HARP HCBS Assessments

- Interim Billing Solution (Pre-Integration of Assessment Data in MAPP) for HARP/HCBS Eligibility Assessment (Brief) and New York Community Mental Health Assessment (Full)

  - ✓ Data on Brief and Full Assessments that were completed for HARP plan members in the prior week will be provided to HARP MCPs on a weekly basis (if not assessments were completed for you plan members in any given week your Plan will not receive file for that week).

  - ✓ The data will be provided to the **HARP plan contact** using the secure file transfer application in HCS

  - ✓ Plans will use this information to submit claims and remit payments to either the Health Home for payment to downstream provider conducting assessment, or other entity if the member is not enrolled in Health Home

- Additional billing guidance will be provided in the HCS notification to the HARP plan contact

- Interim solution will be used to test process and inform the development of the process for Permanent solution to integrating brief and full assessment data in MAPP to allow HARP plans to log into MAPP and download the information they need to submit a Medicaid claim for the brief or full assessments

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Health Home Development Funds

Health Home Development Funds

HHDF Reports are due Semi-Annually, first report was due September 15, 2015

- DOH has received 30 of 31 required reports

- The State reviewed the reports to verify:

  - Completeness – information was reported for all required fields

  - The extent to which the proposed uses of funds conforms with the Federally authorized purposes and other guidance provided by the Department

  - The degree of detailed information provided regarding the requirement that CMAs were involved in and benefitted from funding decisions

  - DSRIP alignment with the Health Home's reported uses

  - Ensure that no more than 30% of HHDF *received* to date were allocated to expenditures prior to 8/1/2014

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Health Home Development Funds

- Based on the September Health Home Learning Collaborative and a follow up survey Health Homes requested the State make available the list of how each of the HHs have proposed to use their HHDFs. Health Homes will have an opportunity to review their information before list is distributed.

- In response to request from HHs, DOH will host a monthly call with Health Homes to provide an opportunity to answer questions and discussion regarding the uses of HHDF.

  - First call will be held in December.

- The next quarterly HHDF payment will be made in December.

Example of HHDF Summary of Uses

Example Health Home A			
Member Engagement and Promotion of Health Homes	**Workforce Training and Retraining**	**Health Information and Clinical Connectivity**	**Joint Governance Technical Assistance and Implementation Funds**
Project Title: Health Home Website Development and Marketing Materials, Health Home Language Line, Annual Care Management/Downstream Provider Conference, Hiring of a Third Party Vendor to focus Outreach Efforts on Patients in Hiatus, General Grants Fund, Search Firm to Assist in Hiring Care Coordination Staff across the Health Home	Project Titles: Grand Round Series, Health Home Language Line, General Grants Fund, Search Firm to Assist in Hiring Care Coordination Staff across the Health Home	Project Titles: Roster Management Application (RMA), Tablets, Connectivity to MAPP/Interfacing with Existing Care Management Platforms/RHIO or SHIN-NY Memberships, General Grants Fund,	Hiring of a Health Home Roster Manager, Health Home Language Line, General Grants Fund, Search Firm to Assist in Hiring Care Coordination Staff across the Health Home,

Behavioral Health Updates

HARP/BH Implementation

- HARP implementation and integration of specialty behavioral health services into mainstream plans began October 1, 2015 for NYC

- Approximately 58,000 HARP eligible individuals will potentially be enrolled in HARPs between October 2015 – January 2016

  - If a person is in an MCO with a HARP line of business, they will be passively enrolled into their Plan's HARP product

  - If a person is in an MCO without a HARP line of business, they will be given the option to enroll in a HARP

- Behavioral Health Home and Community Based Services (HCBS) Eligibility Evaluations (using the interRAI NYS Community Mental Health module) should begin ASAP upon HARP enrollment

- BH HCBS will be available as of January 2016.

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HARP-Eligible Members

- The following are major reasons why a HARP-eligible member may not be pushed to the Plan assignment file:

1) The member is currently in a non-mainstream plan (i.e. MLTC);

2) The member's current coverage code or R/E code is not compatible with the Health Home program;

3) The member has an outreach or enrollment segment that ended in the last three months

- ***The HHTS system will now recognize the Managed Care Plan for members who enrolled in Medicaid through the exchange.***
  - *Note that due to reporting frequencies, there may be a lag in the exchange member's Plan being available to the HHTS.*

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Strategic Task Force: Progress of Enrolling HARP Members Into Health Homes

- Progress: Continued slow, steady increase in outreach/enrollment

- As of October 27, 2015:14,932 (22.3%) Enrolled and 7,624 (11.4%) in Outreach through September, of the 67,000 NYC HARP-eligible members.

  - This is an increase of 216 members Enrolled, and an increase of 1,327 in Outreach for September, compared to data from 3 weeks prior.

  - **23,556** (33.7%) in Outreach and Enrollment combined through September.

  - If we use our revised, current HARP-eligible member denominator of 58,000 instead of 67,000, then 25.7% are Enrolled, 13.1% are in Outreach, and 38.9% are in Outreach or Enrolled, combined.

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Strategic Task Force Progress to Date: 2012 - 2015

- From 2012 through September 2015: 51,450 (76.8%) have been in Outreach and Enrollment combined.
  - 21,892 (32.7%) have been Enrolled from 2012 through September 2015
  - 38,771 (57.9%) have been in Outreach 2012 – September 2015
    - Note - numbers are not additive

NYC HARP-Eligible Member Enrollment in HHs Jan 2015 to Sept 2015 (for Larger Health Homes)
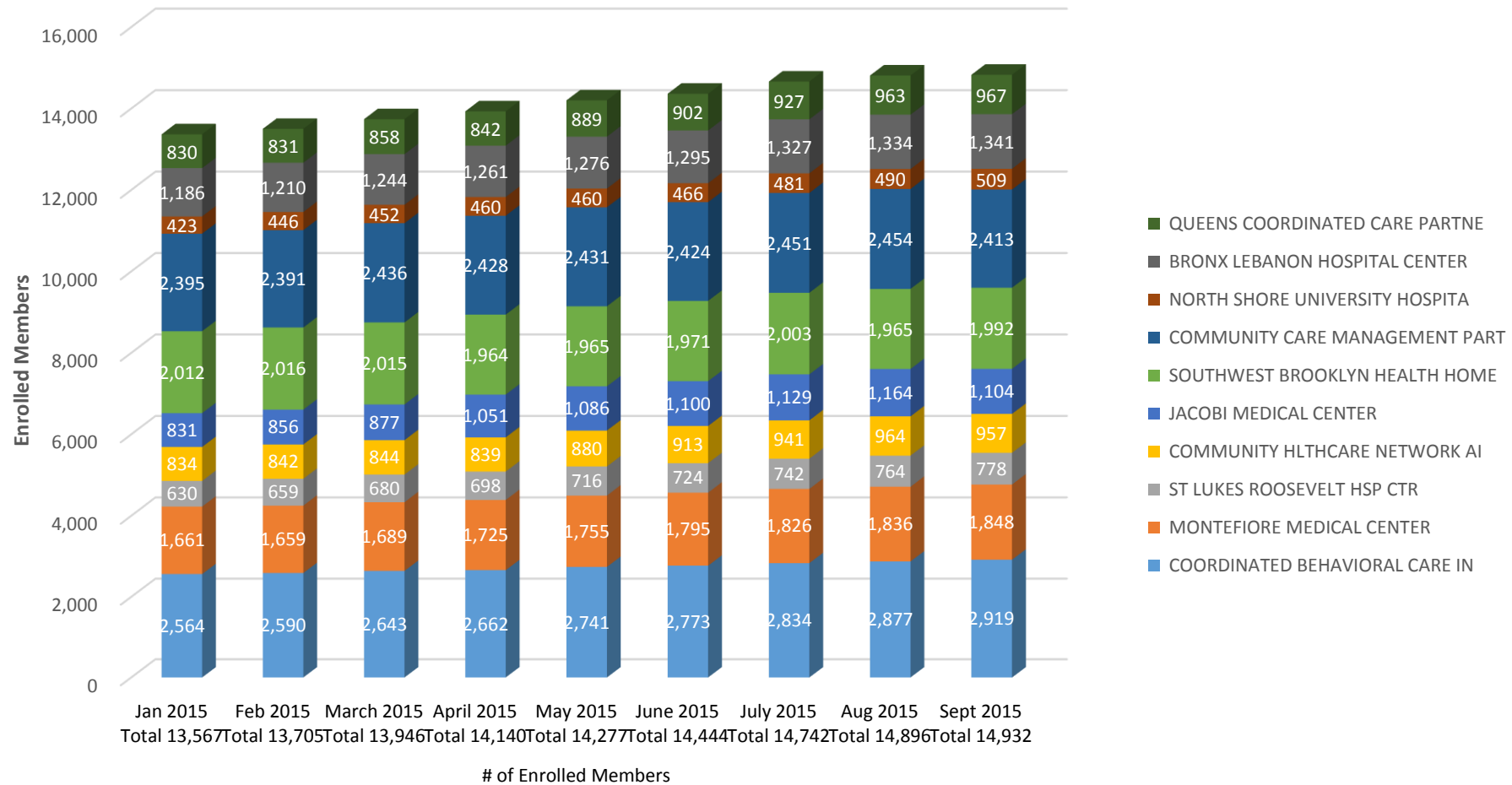
NYC HARP-Eligible Member Enrollment into HHs Jan 2015 to Sept 2015 (for Larger Plans)
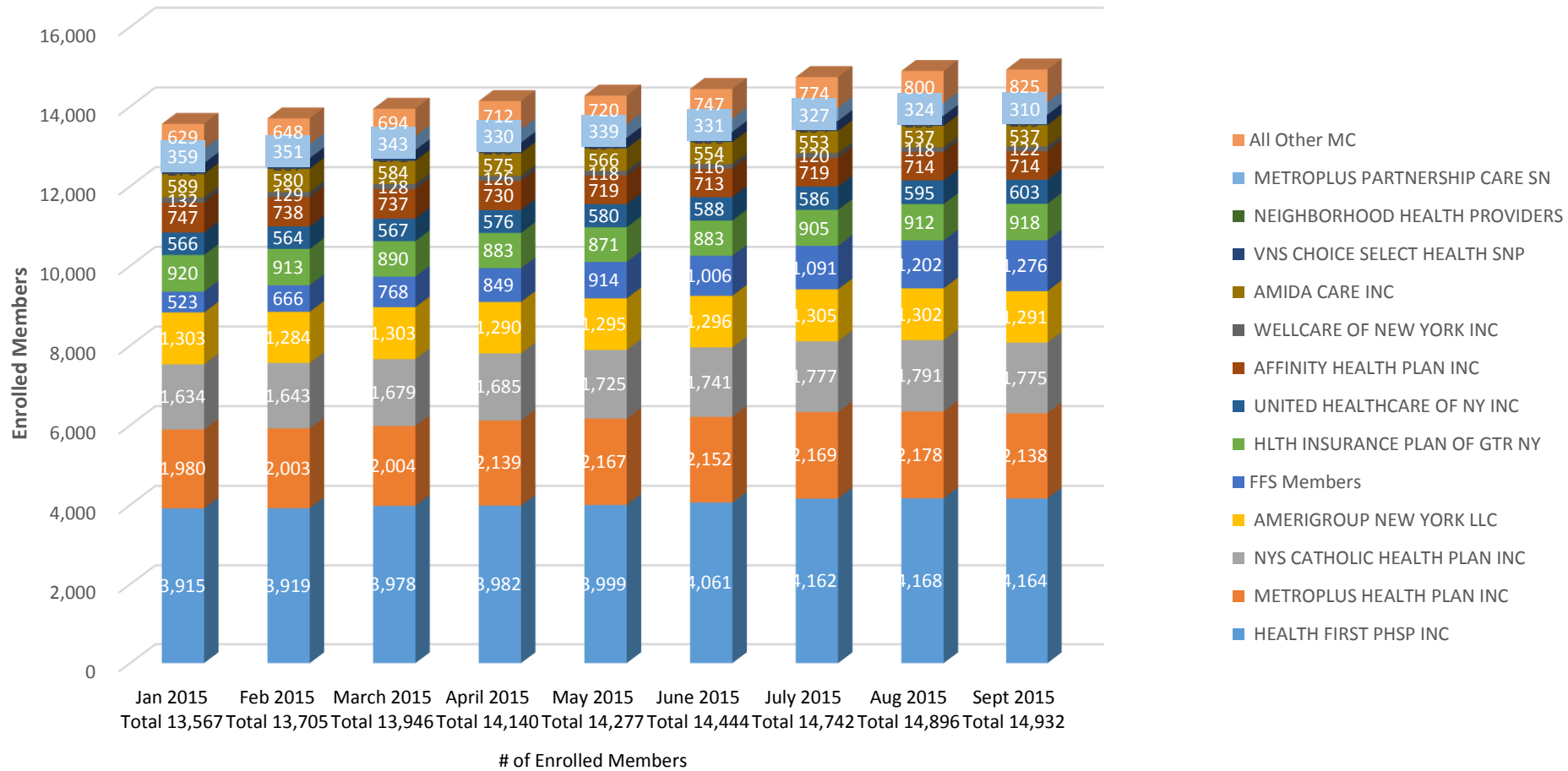
Data-Sharing

- **Guidance to Managed Care Organizations, Health Homes, Care Management Agencies, and Providers:**
  - Sharing Protected Health Information for Outreach to support Enrollment of Individuals in Health Homes
  - Sharing Protected Health Information after Enrollment/Consent have been completed
    - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/guidance_to_mcos_hhs_cma_and_providers_re_info_sharing.pdf
  - Frequently Asked Questions
    - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_phi_guidance_faq.pdf

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Clarifications on Data-Sharing Between MCO and CMA

- This sharing of PHI would require a written scope of work describing the nature of information to be shared and an established Business Associate Agreement and/or other formal assurance to allow exchange of PHI.

- For the BAA of the MCO with the CMAs, we are NOT providing a template per se, but the MCOs can use the BAA agreements between HH and CMAs as their guide.

- The BAA between the Plan and the CMAs could include multiple CMAs

- The standard ASA between HH and Plans has been posted on the Health Homes website and will be distributed to Managed Care Plans

- Once the amended ASA is signed, Plans can then enter into BAA with CMAs.

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MCO Community Health Workers

- MCOs who choose to use Community Health Workers (CHW) should coordinate their efforts with the HH.

- To avoid duplication of efforts, inefficient use of resources and confusing the member, a best practice would be to engage MCO CHWs, with collaboration and communication with the Health Home, when Outreach efforts by the HH have been unsuccessful, and the member never engaged or has not engaged in the past year.

- There is no separate reimbursement for the MCO for Outreach, and HH may not bill for Outreach done by the MCO.

MCOs engaging CHWs should have clear processes and procedures, developed in collaboration with the Health Home, for communicating and coordinating efforts between the MCO and HH

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CMS Conflict Free Care Management Guidance

1. Clinical or non-financial eligibility determination is separated from direct service provision.

2. **Case managers and evaluators of the beneficiary's needs for services are not related by blood or marriage to the individual; to any of the individual's paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health-related decisions on the beneficiary's behalf.**

3. There is robust monitoring and oversight.

4. Clear, well-known, and accessible pathways are established for consumers to submit grievances and/or appeals to the MCO or State

5. Grievances, complaints, appeals and the resulting decisions are adequately tracked and monitored.

6. State quality management staff oversees clinical or financial program eligibility determination and service provision business practices to ensure that **consumer choice** and control are not compromised

CMS Conflict Free Care Management Guidance Continued

7. Track and document consumer experiences with measures that capture the quality of care coordination and case management services

8. In circumstances when one entity is responsible for providing case management and service delivery, appropriate safe-guards and firewalls exist to mitigate risk of potential conflict.

- **Case management functions and direct service provision should be located in different departments within the same organization**

- **Staff should not be rewarded or penalized based on care planning results**

- **The governing structure should be transparent with stakeholder involvement**

9. Meaningful stakeholder engagement strategies are implemented which include beneficiaries, family members, advocates, providers, State leadership, MCOs, case management staff.

NYS Conflict Free Care Management Policy

- To reinforce the implementation and adherence to CMS' Conflict Free Care Management requirements the "HH Standards and Requirements for HHs, Care Management Providers and MCOs" includes the following:

  - Health Homes that provide care management and direct services, must ensure that the provider providing care management is not the same as the provider providing direct care services and that these individuals are under different supervisory structures.

  - Health Home care managers are restricted from assessing a person for whom they have financial interest or other existing relationship that would present conflict of interest.

  - Enrollees shall be provided with a choice of providers from among all of the MCO's network providers of a particular service. Health Homes shall document the enrollee's selection in the plan of care.

End of AIDS Epidemic and Impact on Health Home Members

NYS Blueprint to End the Epidemic by 2020

- Identify persons with HIV who remain undiagnosed and link them to health care;

- Link and retain persons diagnosed with HIV to health care and get them on anti-HIV therapy to maximize HIV virus suppression so they remain healthy and prevent further transmission; and

- Facilitate access to Pre-Exposure Prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) for high-risk persons to keep them HIV-negative.

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HHs, CMAs, MCOs, and HIV Providers Have Key Role in Achieving the Goals of the ETE Blueprint

- Improve rates of viral suppression by implementing best practices to achieve linkage, retention and adherence targets.

- Use existing AI care guidelines that apply to providers.

- Be prepared to report rate of viral suppression of their enrolled population

- Implement interventions for adherence and re-engagement of patients lost to follow-up.

Using Medicaid Match-ETE MCO Pilot

- Plans were given member data that identified those who are not suppressed at last viral load or have no documented viral load.

- Plans used own data to identify those members in need of follow-up, lost to care and not consistently on ARV.

- Plans are using data to group members for follow-up and targeted interventions.

ETE MCO Pilot Partners

- AmidaCare (SNP)
- Fidelis
- Healthfirst
- MetroPlus
- MetroPlus SNP
- VNS SelectHealth (SNP)

Drilling Down the Data: General Findings by Plans

- Greatest proportion live in Bronx and Brooklyn

- Proportion enrolled in Health Home, 26%-35%

- Distribution across buckets similar in each plan

- ARV use-includes proportion not on ARV

- Some with no HIV visits in 2015

- Overlap with sites that have Part A and RAP grants

- Range in plans identified as HARP eligible

Hunches Need Analysis

- Unsuppressed fall into 3 groups

    1) Lost or not engaged

    2) Marginally adherent

    3) Mostly engaged/often suppressed

- Opportunities in Bronx for community collaboration

- Distribution across provider sites varies by plan (DAC to private providers)

Drilling Down Health Home Enrolled

- 33% of total enrolled in HH

- 70% of those enrolled VL >1000

- 10 HIV CMA at least 50 plan members with unsuppressed VL

- 5 HIV CMA at least 100 plan members with unsuppressed VL

HH+MCO+HIV providers Opportunities and Challenges
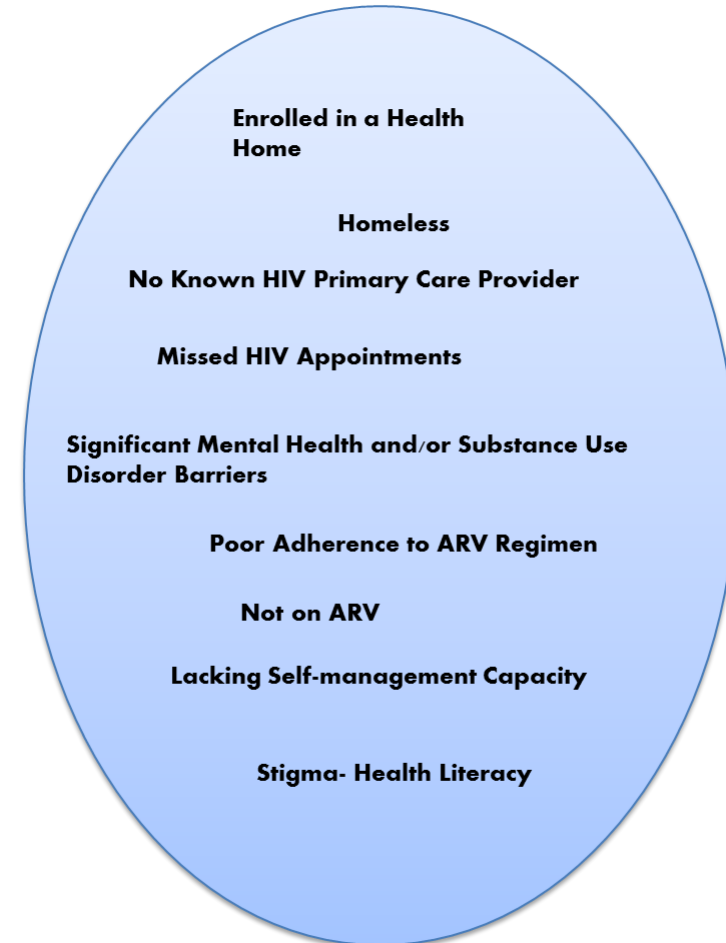
Viral Load Suppression Goals for Target Population.

Assessment of engagement & Adherence barriers.

Joint Service Plan
- **Identifies appropriate intervention**
- **Assigns responsibility for each piece**
- **Monitoring & feedback to all partners**

Clinical
- **Inappropriate ARV regimen prescribed**
- **No experienced HIV provider**
- **85% fill rate of all ARVs**
- **Filling all scripts, poor VLS**
- **Co-morbidities**
- **Lack of supportive services**

Enrolled in a Health Home

Homeless

No Known HIV Primary Care Provider

Missed HIV Appointments

Significant Mental Health and/or Substance Use Disorder Barriers

Poor Adherence to ARV Regimen

Not on ARV

Lacking Self-management Capacity

Stigma- Health Literacy

Challenges Ahead

- Sharing of information

- Effective outreach and enrollment with appropriate CMA

- Lack of HIV Care specific prompts in Lead forms (that mirror ETE goals)

- Integration of CMA and HIV PCP and BH providers in joint service plan

DISCUSSION

Questions, Contact, and Links

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http://www.hivguidelines.org/clinical-guidelines/adults/antiretroviral-therapy/

http://www.health.ny.gov/diseases/aids/ending_the_epidemic/

http://www.health.ny.gov/diseases/aids/ending_the_epidemic/campaign/